Maine Health and Human Services
Elder Services
11 State House Station
Augusta, Maine 04333-0011

John Elias Baldacci, Governor

INSTRUCTIONS FOR MAINECARE HOME HEALTH REFERRAL ATTACHMENT

(Age 21 and older)

Member: Fill in the member's name as it appears on the referral form.

MaineCare #: Fill in the member's MaineCare number.

The referral attachment must be completed for referrals made to Goold Health Systems for MaineCare Home Health assessments. This attachment must:

- Include a certified plan of care or physician orders signed by the member's physician. Check one of the following:

  ☐ *Attached is the Form HCFA-485 Plan of Care signed by the member's physician.* ***OR***

  ☐ *Attached are physician orders for the plan of care at time of discharge. The member is located in a hospital.*

AND

- Provide reason why services are not available and safely accessible to the member on an outpatient basis. Outpatient services must be medically contraindicated or not possible for the member to access. **A reason must be specified on the attachment**. If a reason is not provided the referral will be considered incomplete and result in a delay in determining medical eligibility for continuation of care. This may result in a gap in payment.

  These services are not available and safely accessible to the member on an outpatient basis. Outpatient services are medically contraindicated with likelihood of a bad result.

  Specify reason: _____.

AND

- Indicate what services are required. Check the appropriate box when requesting prior authorization for skilled nursing, physical or occupational therapy, or speech therapy.

☐ *The member's condition requires* ***skilled nursing care*** *on a "part-time" or "intermittent" basis.*

☐ *The member's condition requires* ***physical or occupational therapy*** *as defined in Section 40.02-3(E)-13. Attached is physician documentation of person's rehab potential. Required therapy is related to the following episode (one of the following must be checked):*

- The policy change effective January 20, 2006 includes new requirements when requesting prior authorization for therapies. A referral request for therapies must include a copy of physician documentation that the person has rehabilitation potential. There are additional criteria when a person needs continued physical or occupational therapy. One of three situations had to exist at the start of Home Health services in order to receive therapies under this policy. One of these must be checked when referring for continued therapies.

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- ☐ *treatment following an acute hospital stay for a condition affecting range of motion, muscle strength and physical functional abilities.*
- ☐ *treatment after a surgical procedure performed for the purpose of improving physical function.*
- ☐ *treatment in those situations in which a physician has documented that the member has, in the preceding thirty (30) days, required extensive assistance (defined in Section 40.01-23) with at least one person physical assist (defined in Section 40.01-24) in the performance of one (1) or more of the following activities of daily living: eating, toileting, locomotion, transfer or bed mobility.*

☐ *The member's condition requires **speech therapy** as defined in Section 40.02-3(E)-14. Attached is physician documentation of person's rehab potential.*

NOTE: Referral will not be considered complete until documentation of rehabilitation potential is received when requesting prior authorization for therapies. Eligibility determination will not occur without complete referral. Dates of eligibility may be impacted and result in gap in dates of coverage.

Prior Authorization Required: Check the category of service that you are requesting Goold Health Systems to prior authorize for this member.

- If you are requesting prior authorization for assessment/management, you must indicate the Start of Care Date in space provided.

  ☐ *Member requires additional certification period for unstable medical condition for continued assessment and management as defined in Section 40.06-E.* ***Start of Care Date:*** ___/___/___

  ☐ *Member requires continued home health services.*

  ☐ *Prior Authorization is needed to add additional services to Section 17 plan of care.*

Person completing this form: Sign this attachment in the space provided.

Date: Enter the date that this attachment was completed in the space provided.

Provider Name: Include your provider agency name.

Fax the referral attachment with the referral form and plan of care to Goold Health Systems at **1-800-368-0965**.